MASSACHUSETTS

June 15, 2011

Seena Carrington, Acting Commissioner
Massachusetts Division of Health Care Finance and Policy
Two Boylston Street, 5th Floor
Boston, MA 02216

RE: *Responses to Questions from Division of Health Care Finance and Policy and Attorney General*

Dear Acting Commissioner Carrington:

On behalf of Blue Cross and Blue Shield of Massachusetts (BCBSMA), we are pleased to provide the following responses to the Division of Health Care Finance and Policy (the Division) and Attorney General's questions posed in Attachments B and C respectively in a letter dated May 27, 2011.

Below are detailed responses to the Division's and the Attorney General's questions.

Division of Health Care Finance and Policy Questions

1. After reviewing the preliminary reports located at *www.mass.gov/dhcfp/costtrends,* please provide commentary on any finding that differs from your organization's experience. Please explain the potential reasons for any differences.

BCBSMA Response:

The findings highlighted in the preliminary cost trend reports issued by The Division are consistent with BCBSMA's experience. We have seen disparities in the market place as the reports indicate.

Additionally, we would like to highlight other drivers of increasing medical expenses such as:

- Market Reform: Health care reform mandated the merger of the individual and small group segments in Massachusetts effective July 2007. The individual segment has claims experience and trends that are significantly higher than the group business, due to higher morbidity and unfavorable selection in this non-group segment. This has resulted in increasing per member per month annual trends across all services for the merged small group and individual segment by 4.0%-5.0%.

- Overuse of medical services: Overuse of certain services increases costs unnecessarily. Examples include preventable hospital re-admissions and emergency room visits for avoidable or ambulatory sensitive conditions.

- Regulatory and legislative changes: Regulatory and legislative actions impact costs and trends, such as mandates and assessments on insurers. One example of recently implemented mandates that resulted in increased cost is the PPACA provision to eliminate cost sharing for preventive services. This resulted in premium increases of 1.5%-2.5% for the small group segment. Other examples include state and federal health insurer assessments to fund the state vaccine program as well as the upcoming Patient Centered Outcome Research Institute. Additionally, as noted in the DHCFP report, Massachusetts recently mandated coverage for diagnosis and treatment of Autism Spectrum Disorders and expanded infertility mandate. These assessments and additional mandates resulted in premium increases of approximately 0.6%. Towards that end, DHCFP should aggressively launch the required study of mandated benefits authorized under Chapter 288 of the Acts of 2010.

2. We found that – when adjusted for all factors (benefits, demographics, geography, etc.) – small businesses are paying more for premiums and have experienced sharper growth in rates than mid-size and large employers. Is this finding consistent with your organization's experience? Please comment on why you think this is happening and what can be done to assist small employers.

BCBSMA Response:

Premiums for small groups and large groups are based on separate pools with different underlying characteristics. A single large employer group is much more stable and less prone to adverse selection as compared to several small groups that are combined into one large pool since there is no guarantee as to which small groups will leave the pool at any given time. Additionally, large employer groups generally have controls in place to limit anti-selection like annual open enrollment periods, limited choice of benefit plans, premium contributions and eligibility.

In most markets, medical costs and trends for small groups versus mid-sized and large groups are higher. As highlighted in the DHCFP report, most of the disparity in adjusted premium levels for small groups is due to differences in medical spending. Trends in per member per month costs for small groups are higher than trends in the large group segment.

Small versus large group differentials reflect the impacts of adverse selection, particular regulatory and legislative effects, geographic differences, and the ability to use employer incentives.

Specific to Massachusetts and BCBSMA, additional drivers of this difference include changes made during Health Care Reform. The merged market did not impact large

group claims and trends. As discussed in the question above, the impact of pooling the individual segment was spread over the small group market only.

Some of the drivers of anti-selection due to the market merger have been addressed by the Legislature. The amendments to M.G.L. Chapter 176J pursuant to Chapter 288 of the Acts of 2010 created a new mandatory open enrollment structure for eligible individuals seeking coverage in the small group-individual market ("merged market"). Also, individuals eligible for employer sponsored coverage are not eligible to purchase individual health insurance coverage. Both of these provisions were effective December 1, 2010.

However, Chapter 288 also allows for the creation of small group purchasing co-operatives which will drive further segmentation in the merged market. We are concerned that this may drive further anti-selection in this segment. Co-operatives can apply under Division of Insurance specifications from August 1-15, 2011, and it is expected that the process for selection will last through September 2011. We will be unable to see the full effect of this change for some time.

Moreover, DHCFP notes that individuals have higher average age and smaller family sizes compared to other segments. BCBSMA experience indicates that individuals have higher medical costs and higher prevalence of disease as compared to group members. Also, some individuals continue to enroll on a short term basis for acute care rather than continuing coverage throughout the year due to relatively weak individual penalties.

In order to mitigate the impact of the merged market on the small group premiums we suggest the following:

- Stricter enrollment policies like, waiting periods, premium penalties and coverage exclusions for individuals purchasing insurance for limited periods.

- Strengthening and enforcing penalties for non-compliance with the individual mandate and assessing the penalty on an annual basis rather than prorating, with appropriate exceptions.

- Allowing more rating flexibility to reward healthy behaviors. More specifically, we believe the smoking and wellness factors, that are allowable rating factors in the small group regulations, should be applied outside the 2:1 rate bands.

- Loosening geographic access requirements so that new and innovative provider networks can be developed.

- Creation of a high risk or reinsurance mechanism to fund the added cost of high risk/cost individuals.

3. What are some of the non-medical drivers (not related to health care prices or utilization) that have led to premium growth in recent years? What is your organization doing to minimize their impact on premium costs?

BCBSMA Response:

As DHCFP reports, the primary driver of premium increases are medical costs. Non-medical costs, including administrative expenses, commissions, contribution to reserves, and federal and state taxes comprise approximately 10% of every premium dollar. Per Table 16, BCBSMA consolidated administrative expenses per member per month decreased by 1.4% in 2010 relative to 2009.

BCBSMA has maintained a strong emphasis on containing administrative expenses in order to fulfill our core mission. We anticipate that total administrative spending in 2011 will be at or below 2008 levels. Administrative cost containment initiatives undertaken include:

- Real Estate Initiatives – Implemented site consolidations, ensured energy efficiency, and implemented an e-Working program with more than 750 participants. These items combined to reduce our facilities cost by approximately $6.5 million compared to 2009.

- Associate Benefits – Kept employee Medical Benefit expenses flat for 2010 and reduced certain employee programs significantly. We have introduced our associates to tiered network and high deductible plan options that will allow us to lower the overall cost of providing health insurance to our 3,500 associates.

- Core Operations -Outsourced some key functions that resulted in cost savings. Consolidated Member & Provider Service Operations savings of nearly 8%, and other notices sent via the web saving over 20%.

- Technology Strategies – Various contracts have been restructured resulting in savings. Most significantly, the company has also changed its IT service provider under a modern outsource agreement that allows the company flexibility and reduced maintenance and development cost. This change is estimated to save the company approximately $75M over the five year term of the contract.

- Care Management – Actively managed our outsourced vendor contracts to ensure Care Management activities are maximized. The total cost of these externally vendored programs have decreased by 57% from their highest levels.

- Procurement – Implemented a Center-Led procurement model to ensure more active management of our vendors from the selection process through the performance review process. Shifted focus to maximizing our purchasing leverage in the market by putting more buying out to bid, strategic sourcing, consolidating vendors and implementing demand management strategies.

- Printing – Eliminated internal print shop, outsourced print jobs putting many jobs out to bid, and utilizing electronic printing whenever possible. Consolidated vendors to drive volume advantages.

- Overall Staffing (some included in items above) – Improved efficiencies and managed attrition to reduce staffing needs by 13% or 450 positions since 2008. Our workforce is now the smallest it has been since 2004.

- CEO Compensation – With the urging and approval of our new CEO Andrew Dreyfus, the BCBSMA Board of Directors has substantially reduced the compensation and benefits of the CEO position to the low end of the market range. We believe this compensation is more in keeping with the community's expectations and standards for appropriate, but not excessive CEO compensation.

4. What systemic actions do you think are necessary to mitigate health care cost growth and health insurance premium growth in Massachusetts?

BCBSMA Response:

BCBSMA recognizes the immediate need to control the cost of health care. To reach true cost control, a fundamental change must be made in our model of payment from one focused on volumes (fee-for-services) to one base on value, and with a budget constraint that engages providers in the same goal. The necessary changes will require actions by the key stakeholders – health plans, providers, employers, consumers, and government. While much more work needs to be done in a spirit of shared responsibility, positive signs are emerging that the health care market is beginning to respond.

Rate regulation, often looked to as a solution to health care costs, does not address systemic issues within the current system. Caps on health plan premiums focus on the result (premiums) rather than the causes (underlying costs). This approach fails to recognize that premiums are tied to health care costs. Additionally, it is estimated that significant waste, up to 30%, is occurring in our current system. This unnecessary spending is also not addressed by rate regulation. A sustainable solution will need to address increases in utilization and severity, increases in discretionary services, trends of shifting utilization towards higher cost settings, increased prevalence of chronic conditions and obesity, and an aging population.

BCBSMA believes that an element of reform must be a shift toward paying providers differently. Massachusetts health plans are leading the nation in using innovative provider payment methodologies. For example, BCBSMA introduced the Alternative Quality Contract (AQC) in 2009 as a new provider payment model. The AQC will be discussed in more detail in the below questions.

Early data on the AQC directly shows that establishing accountability for health care quality, outcomes, and costs by changing the payment model will stimulate significant improvements on each central issue.

Other potential solutions to mitigate costs include but are not limited to:

- Consumer and employer engagement through innovative product design and increased transparency of costs and quality to allow customers and providers to better understand the value of the health care services they are receiving.

- Regulatory and legislative solutions including keeping the provisions designed to address adverse selection in the merged market by limiting eligibility to purchase individual coverage strengthened in Chapter 288 of the Acts of 2010, high risk pools or reinsurance mechanisms, and strengthening the individual mandate.

- Reforming the DPH determination of need processes to appropriately limit unnecessary supply growth and incent high-quality, lower-cost options.

- Utilization management programs to ensure appropriate use of services.

- Eliminate opt out provision for tiered or limited networks or establish a usual and customary rate (eg Medicare) for emergency services provided by non-participating providers.

- Greater flexibility on tiered networks and PPO by amending the statute that currently requires benefit levels for out of network to be at least 80% of the benefit levels for services rendered by an in network provider.

- Establish usual and customary rate for out of network providers for all product types.

- Remove tobacco and wellness rating factors from the 2:1 rating band, thereby benefiting small employers and individuals that exhibit healthy behavior.

- Placing a moratorium on new mandated benefits until health care premium inflation is in line with overall inflation.

- Enactment of malpractice reform and peer review statutes previously recommended by the Health Care Quality and Cost Council and in filed legislation.

5. What factors do you consider when negotiating payment rates for inpatient care, facility charges for outpatient care, and physicians, and other professionals? Please explain each factor and rank them in the order of impact on negotiated rates.

BCBSMA Response:

In preparation for and over the course of negotiations, BCBSMA uses many different information tools to assess the hospital's and physician's current and proposed reimbursement levels. These sources include but are not limited to:

- Hospital's audited financial statements, including hospital's 403 and 2552 cost reports;

- Peer group cost and rate analyses;
- Comparison to Medicare reimbursement rates;
- Past claims experience and performance on quality programs; and
- Industry wide analyses and reports (Hewitt, as an example).

BCBSMA contracts with non-facility providers at the individual level and at the group level. This distinction is often affected by the organizational structure of the providers in a given geographic location. Through these negotiations, BCBSMA works to solidify multi-year agreements that include performance measures focused on quality and efficiency improvements, with reimbursement rates determined relative to the value returned to our accounts and members. Some of the key data elements that are utilized in these negotiations are:

- Risk Adjusted Per Member Per Month total medical expense amounts as they compare to the overall network average;
- Performance on key quality metrics; and
- Reimbursement relativities to peer groups

6. Is there a material difference in how you approach contracts when you are contracting with a health care system vs. contracting with organizations representing a single facility or provider group?

BCBSMA Response:

BCBSMA's goal in negotiating each contract with our providers is to deliver meaningful value to our customers through the aggressive negotiation of payment rates for units of service though performance-based incentives. Negotiating with providers that have a strong geographic presence, name or brand recognition, or specialty focus can present negotiating challenges. In general, larger systems work to secure higher rates. BCBSMA and other health plans attempt to strike a balance between prices paid and providing broad access for our members.

However, negotiations that are done at a health care system level present added opportunities as well. By negotiating at the system level, we can build alignment with programs and infrastructure. With larger systems, there are increased opportunities to develop meaningful and measurable performance metrics to increase the value of the contract to all parties. The AQC is one important way of negotiating with these goals in mind and is available to large systems and smaller groups.

7. We understand that certain systems demand higher rates because of geographic isolation, specialty practice and reputation. Please explain your understanding of this dynamic.

BCBSMA Response:

In 1990, Massachusetts had 111 independent acute care hospitals whose payments were set by the state through a commission designed specifically for that purpose. Also, clinical practice was changing rapidly and care was moving from inpatient to outpatient settings. During the period that HMOs formed, not every hospital was in every health plan network. Taken together, these three factors created a situation where Massachusetts had more hospital beds than were required for the population and hospitals were actively competing for patients. With this increased competition, payers generally experienced lower payments. Additionally, most physicians practiced independently and accepted our standard fee schedule.

The landscape has changed dramatically. Hospital mergers and closings have left approximately 70 hospitals, and many physicians have joined with each other to form Independent Physician Associations (IPAs), or with hospitals to form Physician-Hospital Organizations (PHOs) or other integrated delivery systems.

We have also observed that this consolidation has created new dynamics that are affecting health care cost and quality. While it might seem likely that consolidation of physicians and hospitals into large, integrated delivery systems would lead to better coordination and an opportunity for increased quality, current cost trends in Massachusetts have not yet reflected that. For example, the consolidation has resulted in some provider groups who have a stronger negotiating position with health plans because they either:

- Represent the only health care option in a given geographic area;
- Offer specialized care that cannot be delivered by other providers; or
- Enjoy such a strong reputation and patients demand access to their services.

As we negotiate with providers, we are aware of the priority our customers place on having broad access to the doctors and hospitals they prefer in our full network products. In the environment mentioned above, providers have an advantage, knowing that the expectation from our customers is that we will keep all providers in our full network in order to minimize disruption in provider relationships. The result is higher payments to providers and thus higher premiums for all our members.

As payments to advantaged providers have increased, it has created an upward spiral of payments not just to these providers, but to other providers in our network, who argue that without their own pay increases, they are not able to compete with the higher paid players in the market.

In addition, providers are seeking increases because of several other circumstances, including:

- Underpayment from Medicare and Medicaid;
- Need for capital investments; and

- High cost of living in Massachusetts, which leads to higher labor costs for doctors, nurses, and other health care workers.

All of these circumstances are compounded by nation-wide cost trends, including increasing use and intensity of services due to an aging population, the practice of defensive medicine, and the availability of costly new medications, procedures, and technologies. To address these issues, we have taken steps in contracting, including but not limited to, our AQC model, product development with our tiered products, and other initiatives to try to contain costs for our members.

8. What quality measures does your organization use to assess quality outcomes by provider? What incentives or consequences are there for providers based upon their performance?

BCBSMA Response:

The goal of our performance measurement strategy is to advance care to our end-state vision of safe, affordable, effective, quality patient-centered care. We use quality measures that are nationally accepted, reliable, and valid for payment purposes. Providers receive reports on a regular basis to monitor and improve their performance.

Our AQC model and Hospital Performance Improvement Program (HPIP) measure and reward outcomes for all hospitals in our network based on their outcomes. Currently, we have 57 hospitals in the HPIP and of these, 11 hospitals are also in the AQC. Both programs use an aligned set of outcomes measures. For a full list of measures used in our incentive programs, see Appendix A (attached separately).

Under HPIP, hospitals have the potential to earn prospective incentive payments based on the level of performance above the minimum threshold in each component of the measurement program – outcome, process, and patient experience.

Our Primary Care Provider Incentive Program (PCPIP) measures and rewards quality and outcomes for primary care providers who are not in an AQC or other contractually based incentive program. The PCPIP uses an aligned set of clinical process and outcomes measures to the AQC. Under this program, primary care providers have the opportunity to earn an additional per member per month (PMPM) incentive payment paid out twice a year. Providers are rewarded based on group performance for quality measures and on individual performance for efficiency and other measures. The program continues to evolve as the quality measure set has expanded and focused more on outcomes of care versus processes of care.

We believe that the performance measure set including in the AQC is the most comprehensive performance-based incentive program in the nation. The measures encompass ambulatory and inpatient care, and in both settings, include a broad set of measures addressing clinical processes (evidence-based care), clinical outcomes and patient care experiences. There are currently 12 medical groups, representing more than one-third of our network physicians, contracted under the AQC model. Ambulatory measures include indicators of the extent to which evidence-based care is provided with respect to prevention, acute care and chronic care. The ambulatory outcome measures are triple weighted reflecting their extreme importance with respect to improving the

health of chronically ill patient populations. The AQC appears to be the first program to establish provider accountability for the outcomes of care – that is, not solely for the delivery of care in the practice settings, but the results that ensue.

Updates to the AQC model in 2011 have modified the way that quality results are rewarded in the following two ways: (1) Performance on the quality measures is now used to determine the share of the AQC provider's budget surplus or deficit sharing. A provider who achieves a surplus retains a higher share of the surplus if quality scores are higher. A provider in deficit owes a smaller share of that deficit if quality scores are higher. In this way, incentives on quality and efficiency are linked, but using a method that incentivizes AQC providers to achieve the highest possible quality scores regardless of whether they will be in surplus or deficit. (2) Payment for the quality measures is now based on a PMPM basis, rather than being defined as a percent of the provider's global budget. The PMPM approach means that AQC providers who achieve a given level of performance will be rewarded equally for that performance.

9. What role do you think quality should play in determining prices, and does the health care community currently collect the right types of quality measures?

BCBSMA Response:

Quality, coupled with efficiency, should be the leading factor in determining prices. BCBSMA has operated under this principle since 2008 with regard to all provider increases. For physicians, we had 0% standard physician fee schedule rate increases in 2009, 2010, and 2011. Primary care providers had the opportunity for increased revenue for quality performance through PCP Incentive Program. On the hospital side, rate increases since 2008 have been driven largely by HPIP quality results. For hospitals and physicians under the AQC, a significant part of the earning potential for providers is based on quality results as outlined in Question 8. Our incentive program approach has already significantly increased the role of quality results on provider payment.

To assess quality, we employ a robust set of process, outcome and patient experience measures through our claims data and in conjunction with the Massachusetts Health Quality Partner's state-wide ambulatory patient experience. While we believe the AQC was the first incentive program that established provider accountability for performance on clinical outcome measures, we continually expand our program emphasis on outcome measures, as opposed to process. BCBSMA is continuously monitoring the evolution of outcomes measures through the National Quality Forum and at the Centers for Medicare and Medicaid Services (CMS) because we believe this is the future of quality measurement. In addition, we are actively contributing to new outcome measure development and validation through both the "developmental measures" component of our AQC contracts and through our leadership role in the state's Expert Panel on Performance Measurement (EPPM). The EPPM is leading the development, testing and validation of a broad set of clinical outcome measures that will add importantly to our ability to measure, monitor and improve health outcomes throughout Massachusetts.

10. We found that for many inpatient DRGs, a large portion of patient volume is clustered in the most expensive quartile(s) of providers. Please provide your organization's reaction to these findings.

BCBSMA Response:

BCBSMA agrees with the statement above. Our data indicates that a growing percentage of Inpatient admissions and Outpatient services are performed at a tertiary care hospital versus a community care hospital. Approximately 20% of our total annual trend in medical costs in 2009 was driven by care being delivered in more expensive settings. Care delivered in expensive settings is not necessarily better quality, as the DHCFP reports found. The fact that Massachusetts has a greater number of academic medical centers compared to other markets and current consumer perceptions of value play significant roles in where care is presently delivered.

11. What tools should be made available to consumers to make them more prudent purchasers of health care?

BCBSMA Response:

BCBSMA strongly believes that making health care more affordable requires the engagement of all constituencies, including providers, employers and members. This makes it essential to provide these parties with relevant, understandable, and actionable information in an accessible format at the time and place that works for them. We also believe it is important that health plan benefit design and incentives for the various parties be aligned in order to create awareness and reinforce the informed decision-making and behavior change desired. For consumers, we believe that web-based tools, mobile tools, and written information are needed to inform them about how to maximize the value of their health coverage. Specific information should include high or equal quality lower cost choices that are available to them in terms of providers of care, lower cost alternative treatment, and site of service options, prospective estimates of the cost *to them* and the quality of the providers they are considering, as well as robust educational material about wellness, prevention, pharmacy and treatment compliance.

12. What are the advantages and disadvantages of complete price transparency (e.g., consumers being able to see what prices are paid by carriers to different providers for different services) from your organization's perspective? What about complete quality transparency?

BCBSMA Response:

Increased transparency can help inform consumers and engage them as active participants in their healthcare choices. Making the data relevant to consumers and presenting data that will have the desired effect of improving overall quality and affordability requires careful attention to the nature and scope of information. Specifically, we believe that the following two principles should guide the use of cost and quality data to inform consumer's choice of providers: (1) Cost and quality data should be presented together wherever possible. Presenting either without the other can lead consumers to make decisions based on inadequate and imbalanced information. (2)

Information should be presented in a way that is as consumer-centric (that is, specific to the individual's circumstances) as possible. This is particularly important with respect to cost data. When cost information is presented to consumers in the form of provider "price" differences rather than consumer-centric cost information (i.e., marrying provider price with consumer benefits to indicate what an individual's out-of-pocket cost will be), the resulting information is problematic from several perspectives.

- First, the information may not reflect the cost to the consumer. In fact, outside of consumer-centric product designs including tiered products or high deductible products, a consumer may face no out-of-pocket cost differential, and may thus choose the higher cost providers, presuming that this is somehow the most desirable provider. This has been aptly referred to locally as the "Neiman Marcus" effect – a reflection of the view that consumers will often infer that higher price equates to superior quality.

- Second, when the price data (vs. out-of-pocket cost share data) is not directly relevant to the consumer, he/she may make very little, if any, use of the information.

- Third, when cost transparency takes the form of provider price transparency, it can lead providers to engage in a "race to the top," where all but the highest paid providers use the reported price disparities to seek increases.

Available evidence suggests that fewer than 5% of consumers make health care decisions based on publicly reported cost or quality information. Local experience with use of the MyHealthCareOptions website is no different. We believe that effective engagement of consumers through transparency must begin to present data in consumer-centric ways. With respect to cost, this will mean employing tools that marry benefit information with price information to allow consumers to see how their out-of-pocket cost varies by provider. With respect to quality this will mean employing measures that are much more focused on health outcomes and patient care experiences, rather than the more abstract indicators of clinical process quality that are emphasized today.

13. What methods, if any, does your organization use to encourage consumers to use high value (high-quality, low-cost) providers? What has been the effectiveness of these actions?

BCBSMA Response:

BCBSMA uses benefit design in conjunction with member decision support tools to encourage consumers to use high-value providers. We continue to develop and enhance plans that drive high value care in the system. Our tiered network plan design categorizes PCPs and/or hospitals into three levels based on cost and quality. Member cost sharing varies for each tier: members have the lowest cost sharing when they see lower cost providers who have met our quality benchmarks and members experience higher cost sharing when they see providers with higher cost or who did not meet our quality benchmarks. We have also recently introduced a Hospital Choice Cost Sharing benefit design, which offers members lower co-pays when they receive services at high value facilities. Under this benefit, hospitals are measured on the same cost and quality

measures as the tiered product to assess value. These benefit plans are relatively new to the market so we are only now beginning to measure the experience to determine if there have been changes in behavior. The receptivity of these plans by our customers, even at this early state, shows an intuitive understanding and acceptance of the principle of encouraging the use of high value providers through benefit design incentives.

Our tiered network plan now has more than 100,000 members and our Hospital Choice Cost Sharing plan has had the fastest uptake of any product in BCBSMA history. Each of these products offers a premium discount of about five percent relative to products with comparable benefits. The tiered network products offered by BCBSMA reflect a 5.0% - 30.0% premium differential relative to full network products that are actuarially similar to Tier 1 benefits. Membership levels are not yet sufficient to yield credible evaluation data.

Our suite of member decision-support tools give members the information they need to seek out high value care. BCBSMA recently introduced the NCCT web based tool for our PPO members and employer groups. As explained earlier, the tool provides members with comparative costs for all services related to an episode of care in very tight ranges for BCBSMA network providers with sufficient volume of the procedure. BCBSMA also pairs this cost information with quality information where applicable, based on our Blue Distinction designation for providers throughout the country. In collaboration with all other Blue plans nationally, BCBSMA members may also find similar information for providers in any Blue PPO network around the country. This tool was launched in March 2011 and will be an important initial step in providing BCBSMA members with provider specific cost and quality information transparency. In fact, we are engaged in active planning to extend our scope and capabilities for providing this information.

In addition to the noted methods, the AQC promotes providers to encourage members to use high value providers. High deductible plans also provide consumers with an added layer of transparency to the costs associated with their care.

14. Does your organization currently offer limited or tiered network plans? If so, please describe the level of interest and/or participation from groups and individuals, as well as any feedback you are aware of from those participating.

    a. Please also provide premium differences between the limited/tiered plans and comparable plans that have more open networks.

    b. Please also provide information about how you market and explain these options to employers and consumers.

BCBSMA Response:

BCBSMA currently offers tiered network plans, one known as Options and the other as Hospital Choice Cost-Sharing. The membership in our Options plan has grown five times over since 2009. For Hospital Choice Cost-Sharing, we are experiencing the fastest launch of a new produce in BCBSMA history.

Our tiered network plans are priced roughly 30.0% lower than a full network product with benefits that are actuarially similar to Tier 1 benefits. Our Hospital Choice Cost Sharing benefit design is priced roughly 5.0% lower than comparable benefits in non-tiered products.

BCBSMA makes our tiered network plans available to individuals, small group and large group employers both in HMO and PPO. We offer these on a direct basis and through brokers and benefit consultants who may be utilized by employer groups. We also continue to make available plans that do not include tiered networks or benefits for those who prefer these plans with uniform cost sharing for services. Because of the newness of these tiered plans and the unique features, before we introduced these plans to the market, we provided extensive training and information to our sales and broker business partners so they would be able to explain to employers and members how these plans work. We present the choice of a tiered network plan as an option for those purchasers seeking a cost effective plan, which can lower their premiums, while not reducing benefits, when members use a lower cost provider. In many cases, tiered plans are selected by employers as an alternative to introducing deductibles or increasing deductibles in order to manage their costs. Prior to the purchase we make available tools that can help a purchaser understand these new plans and determine potential disruption for them or their employees. Once the purchase is made, BCBSMA offers many levels of support for new members in these plans, from web based tools through our Plan Education website, provider directory information, an animated interactive tool regarding the choice of provider and impact on member costs in these plans.

We provide information to employer groups and members enrolled in our tiered plans regarding which tier the provider is in and the reason for their tier placement, such as low, moderate or high cost, passing or meeting our quality benchmark or a combination of both. This information is provided on-line and in our provider directory. Members may search for a provider by tier or check the tier or a provider by accessing our on-line search tools. Additional information is available which explains the tiering methodology, the terms used and general information about how members may maximize the value of their benefits by using a high quality, lower cost provider. We re-tier our network on a periodic basis in order to use more up to date data and reflect changes in provider quality performance or cost. We do this no more frequently than once per year for hospitals and no more frequently than every two years for primary care providers, in order to ensure opportunity for measurable changes in performance.

15. Please respond to the trends presented in Table 20. The total medical spending portion of premiums appeared to slow for 2009-2010 as compared to previous years. If your organization also experienced slowed medical spending, please explain the underlying factors. If your organization did not experience the slow-down in trends, please explain why your organization differed from the average.

BCBSMA Response:

Consistent with trends seen nationally and locally, BCBSMA did experience a slowdown in the growth in total medical spending for 2009-2010.

In addition to benefit buy-down noted in the DHCFP report, factors driving slowdown in medical spending levels include:

- Environmental factors like the impact of the recession on the use of discretionary medical procedures. Additionally, elimination of the federal COBRA subsidy in May, 2010 alleviated pressure on medical cost trends due to increased enrollment in COBRA resulting from the subsidy.

- Comparatively milder flu season.

- Specific to BCBSMA, factors include:

    a. More modest fee-for-service contracts with hospitals and physicians as well as improved quality of care and overall reduction in utilization trends observed for AQC providers; and

    b. Care management and wellness programs, such as pharmacy proton pump inhibitors (PPI) initiatives, that help members achieve the most appropriate care, manage chronic illness and live healthier lifestyles.

16. Does your organization have any direct experience with alternative payment methods (bundled payments, global payments, etc.)? What has been you experience and the results in terms of quality performance and cost mitigation?

BCBSMA Response:

BCBSMA is working to change the way we pay for health care service and reward the quality and efficiency – not quantity – of care our members receive. We've established an innovative global payment model for addressing quality and affordability called the Alternative Quality Contract (AQC). The AQC combines a per-patient global budget with performance incentives based on nationally endorsed quality measures over a five year period.

In the first year of the AQC (2009), the improvements in the quality of patient care were greater than any one-year change seen previously in our provider network – well exceeding both the rates of improvement on quality measures that AQC groups were achieving prior to the contract, and exceeding rates of improvement among non-AQC physicians. Within the BCBSMA network, physicians who are part of an AQC group performed much better than those outside of an AQC arrangement on important process measures of preventive care and of chronic disease care. AQC groups also achieved remarkably high performance on clinical outcome measures. In fact, for several of the clinical outcome measures, performance among AQC groups who worked on these measures in year one is approaching or has reached the highest levels of quality believed to be attainable for a patient population. Early results of the AQC provide compelling evidence that establishing provider accountability for health care quality, outcomes and costs by changing the payment model can stimulate significant improvements in all three areas.

In terms of costs, the AQC is on track to achieve its original goal of reducing annual health care cost trends by one-half over the five years of the AQC contracts while continuously improving quality. At the same time, all AQC groups met their budgets in the first year, allowing investments in important infrastructure and other improvements,

such as care managers and electronic data sharing between physicians and the hospital. Infrastructure investments will help provider organizations deliver care more effectively and efficiently. The AQC has already positively impacted two major health care cost drivers — hospital readmissions and the use of emergency rooms (ER) for non-emergent care. We expect these cost mitigation trends to compound as the contract goes on over the next four years.

17. Please identify any additional cost drivers that you believe should be examined in subsequent years and explain your reasoning.

BCBSMA Response:

Additional cost drivers that we believe should be examined in subsequent years are:

- Merged Market Reform: Health care reform mandated the merger of the individual and small group segments in Massachusetts effective July 2007. The individual segment has claims experience and trends that are significantly higher than the group business, due to higher morbidity and anti-selection in this segment. This has resulted in increasing per member per month trends across all services for the merged small group and individual segment by 4.0%-5.0%.

- Cost shifting from public to private payers and the impact on commercial insured medical costs.

- Overuse of medical services: Examples include increased rates of hospital admissions and emergency room visits for avoidable or ambulatory sensitive conditions, preventable readmissions, and increased use of orthopedic procedures related to hips, knees and backs.

- Regulatory and legislative actions that impact costs and trends like mandates and assessments on insurers. Examples of recently implemented mandates that resulted in increased costs are the recent assessments on a state level, as well as the expansion of the federal mental health parity law.

- Restricting non-network charges to address the significantly higher reimbursement rates paid to providers that chose not to participate in BCBSMA's provider network. Out-of-network providers charge rates as much as 3 to 5 times higher than BCBSMA's in-network providers. We estimate that the use of out-of-network providers by our members adds as much as $80 million annually in unnecessary health care spending for our customers.

- Strengthening the determination of need processes to limit supply growth and allow for the introduction of new, more efficient settings of care.

18. Please provide any additional comments or observations you believe will help to inform our hearing and our final recommendations.

BCBSMA Response:

BCBSMA is committed to being a responsible guardian of the valuable health care premiums entrusted to us. In this regard, we have taken steps to run our business more efficiently and effectively. We launched an intensive effort to reduce our administrative costs and shrink the ten cents of every premium dollar it takes to run our business. This effort is centered on finding new efficiencies that will enable us to continue to fulfill our broader mission to our members, customers, and the community.

While these savings are important, we note that they only make a small dent in reducing the overall health care cost trend. That is because administrative costs make up only a small fraction of overall health care costs. On the other hand, medical costs, including hospital costs, professional physician costs, ancillary provider costs and pharmacy make up fully 90 percent of every dollar of premium.

The real opportunity to lower health care costs is by working aggressively to lower medical costs. The solution to addressing affordability in health care must address the true cost drivers, which include increases in the cost per service, the shift from less expensive sites of service to more expensive sites of service, increases in the utilization and intensity of services.

Many experts believe that a large portion, up to 30%, of our health care dollars is wasted. This unnecessary spending could be eliminated without reducing the quality in care received by consumers. This wasteful spending must be addressed moving forward as we consider ways to improve how care is administered, managed, and delivered in the Commonwealth. Global payment models, like the AQC, are a way to start addressing this systemic waste.

The AQC contract model is an important component of a needed overall strategy to align payment reform, performance measurement, provider and member incentives, and increased transparency of cost and quality information to achieve the twin goals of improving the quality and affordability of health care for our members, providers and employers. BCBSMA is interested in advancing this model, along with other solutions. It should be kept in mind that solutions take time and change will not happen over night. BCBSMA believes that with all stakeholders working together towards a solution, we can reach our cost containment goals over time.

Attorney General Questions

1) Please explain and submit a summary table showing the range of your aggregate health status adjusted relative commercial prices or payments from 2009-2010 for each acute care hospital and large physician group in Massachusetts (i.e., physicians who contract through a PHO, IPA, multi-specialty group, or other group arrangement). If the aggregate health status adjusted relative commercial prices or payments from 2009-2010 that you submitted to the Office of the Attorney General differ from the information provided to the Division of Health Care Finance and Policy, please explain the differences and why such differences exist.

BCBSMA Response:

Appendix B, summary table included in a separate attachment.

- Relative Price, Inpatient for 2009 (B.1), 2010 (B.2)
- Relative Price, Outpatient for 2009 (B.3), 2010 (B.4)
- Relative Price, Physician Group for 2009 (B.5)

The above tables are consistent with the information provided to the Division of Health Care Finance and Policy. The data is not health status adjusted.

Physician Group Relative Price data for 2010 is unavailable at this time and will be calculated for the Division of Health Care finance and Policy submission deadline of June 1, 2012.

2) Please explain and submit documents to support how you quantify the amount of, and adjust the amount of, risk being shifted to providers in your network, including risk on self insured as well as fully insured plans. Include in your response any distinction you make between performance and insurance risk.

BCBSMA Response:

There are many factors that are evaluated through the course of negotiations with providers. With provider groups that are actively engaged in discussions and willing to explore a risk based contract model, factors that need to be reviewed include, but are not limited to, the groups' size, experience with risk arrangements, solvency, and infrastructure to effectively manage under a risk arrangement. These factors provide guidance to BCBSMA in negotiating the level of risk we are willing to shift to the provider groups.

Based on this analysis and discussion, several contract elements are used to vary the level and type of risk assumed by the provider. Some of the key elements include: overall risk share percentage, caps on the overall financial exposure, health status adjustments, and catastrophic claim adjustments. The overall goal is provide a meaningful incentive that focuses on factors of total cost within a provider's control and to limit factors outside that control or the impact of random variation.

3) Please explain and submit documents to support how you quantify the total amount that you negotiate to pay at-risk providers on their total commercial business including HMO and PPO, risk and fee-for-service payments. Include in your response how you value any various aspects of provider risk contracts (e.g., carve-outs for certain services such as behavioral health or high cost pharmaceuticals; attachment points beyond which services are not chargeable against the risk budget; quality payments; fees; and other similar negotiated aspects of the contract).

BCBSMA Response:

BCBSMA approaches each negotiation with an at-risk provider with the goal of solidifying multi-year agreements that include performance measures focused on quality and efficiency improvements and that have reimbursement rates based on the value returned to our accounts and members. Some of the key data elements that are utilized in these negotiations are:

- Risk-adjusted Per Member Per Month total medical expense amounts as they compare to the overall network and regional averages;
- Performance on key quality metrics; and
- Reimbursement relativities to peer groups.

BCBSMA evaluates each proposal and agreement in totality to assess the value to our membership and the appropriateness of the terms for the particular provider group. Through risk deals like the AQC, BCBSMA aims to ensure the scope of the risk deal includes all aspects of the patients care and avoids carving out components of care from the risk arrangement. Each arrangement includes a requirement for the provider group to obtain coverage for catastrophic cases and defers to the provider organization in determining the appropriate attachment point, with overall approval by BCBSMA. The value of quality incentives is based on provider organizations performance against nationally accepted quality metrics. Risk levels, withhold amounts, and other aspects of these risk arrangements are also evaluated as one component of the larger arrangement in order to value the arrangement and ensure the appropriateness of the arrangement and its terms to the provider group.

4) Please explain and submit a summary table showing the range of health status-adjusted fully-loaded total medical expenses you paid on a per member per month basis from 2009-2010 for each Massachusetts provider in your network who contracts through a PHO, IPA, multi-specialty group, or other group arrangement, with each provider identified by whether it was paid based on a negotiated per member per month amount against which all allowed claims costs are settled for the purposes of determining the amount of withhold returned, surplus paid, and/or deficit charged to a provider. "Fully-loaded" means inclusive of all administrative, medical management, and other supplemental payments, including but not limited to bonuses, grants, infrastructure funding, and reinsurance recoveries. If the health status-adjusted fully-loaded total medical expenses you paid on a per member per month basis from 2009-2010 that you submitted to the Office of the Attorney General differ from the information provided to the Division of Health Care Finance and Policy, please explain the differences and why such differences exist.

BCBSMA Response:

Appendix C, summary table included in a separate attachment.

- TME for 2009 (C.1)
- TME for 2010 (C.2)

The above tables are consistent with the information provided to the Division of Health Care Finance and Policy.

5) Please explain and submit a summary table showing your premium trends from 2005 to 2010 with details on how much of your premium trend resulted from increases in administrative costs, reserve practices, and medical trend, including the proportion of medical trend that resulted from (1) health care provider unit price increases, (2) changes in utilization, and (3) all other factors, such as changes in mix of services, mix of location of services, member demographics, and plan design. Please explain how you track each of these components with respect to providers in your network who are paid on a per member per month budget arrangement (whether at-risk or "upside only").

BCBSMA Response:

a. The table below summarizes the components of net premium pmpm trends from 2005 to 2010 for the Insured Commercial medical business.

	2005	2006	2007	2008	2009	2010
Use Trend	3.3%	2.8%	2.9%	2.5%	2.8%	3.2%
Severity Trend	3.1%	2.7%	2.8%	2.4%	2.0%	2.1%
Unit Cost Trend	7.3%	7.6%	6.9%	5.7%	5.6%	5.8%
Admin Trend	0.1%	0.5%	1.0%	0.6%	0.4%	-0.2%
CTR Trend	-0.2%	1.0%	0.8%	0.0%	0.1%	-0.5%
All Other	-5.4%	-9.7%	-7.8%	-5.7%	-6.0%	-6.6%
Net Premium Trend	7.9%	4.1%	6.1%	5.4%	4.7%	3.5%

Rating analysis for accounts renewing in the first quarter for each calendar have been used to develop components of premium.

Unit cost: This component of trend represents the increase in the cost of services. More specifically these are the annual increases for specific services, like an office visit or a hospital admission, most often negotiated with the providers of care. Drivers of the unit cost increases include the high cost of living and labor expenses, investments in e-technology, and cost shifting to private payers from public payer shortfalls.

Utilization trend: This component of trend can be defined as the increase in the number of services or units of service provided over a period of time. Examples of units of service include the number of inpatient admissions, number of office visits, Emergency room visits, lab or diagnostic services. Drivers of changes in the utilization of health care services include aging and deteriorating health status of the population and consumer demand for services. BCBSMA has implemented various chronic disease management, utilization management and care management programs over the past few years to address this trend.

Severity: This component of trend includes provider mix, which represents the shift in the setting where medical services are provided. The increase in the intensity of services provided is also included in this category. Increases in this component of trend result from services shifting from lower cost settings to higher cost settings. Drivers of provider mix include consumer demand, expansion of capacity in more expensive settings and physician practice patterns. Major drivers of changing intensity of services include provider adoption of new technology or services as well as consumer demand for those more expensive high tech services.

Administrative Expenses: The 10 cents of every premium dollar that covers administrative costs include salaries and benefits of our employees, technology investments, and a wide range of care management programs for our members. Blue Cross and Blue Shield of Massachusetts has continuously expanded and enhanced our wellness and disease management programs to improve the health of our members and the affordability of health care. Some components of administrative expenses such as broker commissions increase at the rate of premium.

Contribution to Reserves (CTR): CTR targets include risk margins built into the premiums as protection to cover potential risks (operating, strategic, catastrophic, and regulatory). This component of premium also includes taxes (federal income tax and premium tax), where applicable. CTR's primarily increase at the rate of premium trend to keep up with the underlying risk. Drivers of the change in CTR targets over time include changes in benefit distribution across the book of business, updates to the CTR levels based on projected risks, change in tax status and the impact of strategic business decisions.

All other: This component includes the impact of changes in the mix of business including benefit buy-downs and demographics. It also includes changes in projected provider performance payments that may be earned against a budget or for achieving quality benchmarks. Finally, this includes the variance of actual components of premiums varying from projected pricing assumptions.

6) Please explain and submit supporting documents that show what affect, if any, limited network or tiered products have had on premium trend.

BCBSMA Response:

The tiered network products offered by BCBSMA reflect a 5.0% - 30.0% premium differential relative to full network products that are actuarially similar to Tier 1 benefits. Membership levels are not yet sufficient to yield credible evaluation data.

7) Please provide a summary table showing your membership by year from 2005-2010, including: (1) what percent of your members are enrolled in HMO/POS PPO, and indemnity, (2) within each product category (HMO/POS, PPO and indemnity), what percent of your members are fully-insured, self-insured, or other, and (3) within each

product category (HMO/POS, PPO and indemnity), what percent of your members are enrolled in tiered or limited network products.

BCBSMA Response:

Appendix D, detailed spreadsheet including requested enrollment data is included in a separate attachment.

8) Please explain and submit supporting documents that show how you evaluate the capacity of a provider to participate in a risk contract, including factors such as the provider's solvency, historical experience with risk payments, size, organizational structure, ways in which you adjust the provider risk budgets, and any other factor.

BCBSMA Response:

As BCBSMA enters into risk arrangements with provider groups the negotiations include discussions around withhold values, solvency, infrastructure, and prior risk experience. These discussions are intended to help determine a provider group's ability to absorb risk.

With a robust provider network across the state BCBSMA has often had a pre-existing contractual relationship with the organization looking to transition to a risk based model. In reviewing that historic relationship, BCBSMA can evaluate past performance on incentive programs with lower levels of risk to gauge the appropriateness of a risk model. In addition, BCBSMA often looks to the organization's infrastructure to assess the level of alignment across a group's constituency. Past experience has indicated that groups with strong infrastructure, analytic capabilities, and strong clinical leadership are often able to manage within the constructs of a risk arrangement.

There are several factors that may come into play through these discussions that enable us to adjust the risk levels to maintain the focus on cost and quality while ensuring the applicability of a risk-based model for a specific provider group. Examples of these factors may be the level of risk sharing both in a surplus and a deficit scenario, the presence of withholds, and possible caps on surplus and/or deficit levels. Adjusting these factors can minimize the potential deficit levels or anticipate possible deficit expenses while encouraging behavioral changes that drive quality, efficiency and ultimately success in a risk arrangement.

9) Please explain and submit supporting documents that show whether and how you inform your members, or require providers to inform your members, when you reimburse providers for the services that they render to your members through a negotiated per member per month amount against which all allowed claims costs are settled for the purposes of determining the amount of withhold returned, surplus paid, and/or deficit charged to a provider (regardless of whether those providers are "at risk" or are "upside only").

BCBSMA Response:

In working with AQC providers and through additional research, BCBSMA found that communication to members around reimbursements is best given by providers themselves.

However, BCBSMA continues to provide this type of information to our members directly through both the on-line "Find a Doctor" directory, accessible through the BCBSMA website, and through printed provider directories BCBSMA informs members how providers are reimbursed for services. Explanations of the payment practices are explained in the introductory section of the provider directories. Sample pages from the directory and a screen shot from the on-line resource are included in a separate attachment (Appendices E, F, and G).

10) Please explain and submit supporting documents that show how you identify, audit, and/or prevent provider underutilization of needed services or avoidance of sicker patients where you reimburse those providers through a negotiated per member per month amount against which all allowed claims costs are settled for the purposes of determining the amount of withhold returned, surplus paid, and/or deficit charged to a provider (regardless of whether those providers are "at risk" or are "upside only").

BCBSMA Response

BCBSMA takes a multi-faceted approach to ensuring against underutilization of services and avoidance of sicker patients among providers in our AQC arrangement. Firstly, in the AQC model, provider groups are assessed on a robust set of clinical process, outcome and patient experience measures on a regular basis and a significant share of their payment incentive is linked to performance on that set of quality measures. As one example, Appendix H shows the ambulatory quality performance report that our AQC groups receive on a monthly basis – including the member-level detail that calls their attention to "gaps in care" needed by individual members in their panels (see page 2 and 3 of Appendix H). In addition, we employ an ongoing set of care management programs that monitor for "gaps in care" among our members and that actively outreach to members to address these (whether they are in an AQC or not). For example, if we see gaps in care, if members are hospitalized or have frequent emergency room visits and/or have high risk scores, we reach out to them to ensure that they are getting access to needed services. Our health coaching program (Healthways) engages members considered at-risk based on health status or lifestyle/behavior characteristics, and does so across our full member base – regardless of whether the member has an AQC provider. As a complement to these programs and our AQC contracts, we currently have nurse care managers placed on-site with several AQC groups to do outreach and engagement with BCBSMA patients in those practices to make sure they are getting all the services they need in a coordinated and patient-centered way.

With respect to the potential avoidance of sicker patients by AQC groups, BCBSMA takes several important steps to prevent this. First and most importantly, the global budgets are adjusted based on the acuity of the AQC provider's population. As that acuity changes, the budgets change accordingly. Providers who lose sicker members of their population could see significant diminution of their PMPM budgets because those budgets are health status adjusted. In addition, on a monthly basis, BCBSMA evaluates patient turnover in the AQC practices, relative to their own historical patterns and relative to the network. This would serve as an early warning signal for any AQC provider who

was inappropriately dropping or avoiding sicker patients. Appendix I shows analysis that we run and monitor on PCP change. Further, our member service staff has been trained in a series of questions that are asked of any member who calls to change PCPs or to report a complaint about their care. If a complaint about access to or quality of care arises during the call, BCBSMA outreaches to the provider organization to follow-up and resolve. If the issue is unable to be resolved promptly or occurs repeatedly with a particular physician, the issue is escalated to our network management team.

_____ End of Responses_____

I affirm that the facts contained in the preceding response are true to the best of my knowledge. This document is signed under the penalties of perjury. I have relied on others in the company for information on matters not within my personal knowledge and believe that facts stated with respect to such matters are true.

Sincerely,

Patrick Gilligan
Senior Vice President for Health Care Services